



California State Board of Pharmacy

400 R Street, Suite 4070, Sacramento, CA 95814

Phone (916) 445-5014

Fax (916) 327-6308

www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

INTERN PHARMACIST REGISTRATION INSTRUCTIONS

TO APPLY FOR REGISTRATION AS AN INTERN PHARMACIST IN CALIFORNIA, YOU MUST BE:

- Presently enrolled in a school of pharmacy recognized by the board or accredited by the Accreditation Council for Pharmaceutical Education (ACPE),

OR

- A graduate of a school of pharmacy recognized by the board or accredited by the Accreditation Council for Pharmaceutical Education (ACPE) who also has an application pending to take the California pharmacist licensure examinations,

OR

- A graduate of a foreign pharmacy school who has obtained certification from the Foreign Pharmacy Graduate Equivalency Committee (FPGEC). **NOTE: You will not be issued an intern registration until the board has received written verification from the FPGEC that you have obtained this certification. [This process will take up to 12 weeks for the FPGEC to provide your results to the board.]**

OR

- A person who has failed the pharmacist licensure examination four times and has reenrolled in a school of pharmacy to satisfy the requirements of Business and Professions Code section 4200.1.

SUBMITTING AN INTERN LICENSE APPLICATION

To be considered complete, an intern license application must include:

1. **A completed *Application for Registration as an Intern Pharmacist*** (Form 17A-17). All questions must be answered and you must sign and date the form. A 2" x 2" passport type photo must be taped to the face of the application. Photos taken by **personal** Polaroid cameras are unacceptable.

If you are currently enrolled in a school or college of pharmacy, the dean of that school must complete and sign the certification area on the application, and emboss the application with the school's seal.

2. **A check or money order** in the amount of \$65, made payable to the "Board of Pharmacy." Your cancelled check is verification that your application has been received. If you would like notification from the board that your application was received, please submit a postcard addressed to yourself with adequate postage affixed. The board will mail this postcard when your application is received.
3. **A copy of Request for Live Scan Service Form** verifying that your fingerprints have been scanned and all applicable fees have been paid. Refer to "*Instructions for Completing Request for Live Scan Service Form*" on the board's Web site (www.pharmacy.ca.gov). The board can only accept Requests for Live Scan Service Forms that were processed in California.

If you are unable to have your prints taken using Live Scan in California, you must submit rolled fingerprints (on cards provided by the board) and a fee of \$66 made payable to "Board of Pharmacy." (This fee covers: \$32 California Department of Justice processing fee, \$10 expedite fee and \$24 FBI processing fee.)

Contact the board at (916) 445-5014 to request fingerprint cards. Fingerprint cards are to be used **ONLY** when you cannot have your prints taken in California using Live Scan. Fingerprints on cards must be taken by a person professionally trained in the rolling of prints. Poor quality prints will result in the prints being rejected and will require that you be reprinted. Reprinting may delay licensing.

4. **A Rules of Professional Conduct Affidavit.** This form must be signed and dated by applicant.
5. A copy of the **FPGEC certificate** if you are a graduate of a foreign school of pharmacy.



APPLICATION FOR REGISTRATION AS AN INTERN PHARMACIST

TO BE COMPLETED BY APPLICANT

Last Name	First Name	Middle	Former	TAPE A PHOTOGRAPH TAKEN WITHIN 60 DAYS OF THE FILING OF THIS APPLICATION NO POLAROID
*Address of Record:	Number	Street	Apartment No.	
City	State	Zip Code		
Residence Address: (if different from above)	Number	Street	Apartment No.	
City	State	Zip Code		
Home telephone number	Work telephone number	Date of Birth	Social Security Number **	Email address
()	()			

If you are a graduate from a foreign school of pharmacy provide:

Name of School:	Country:	Date Graduated:

*Once you are licensed with the board the address of record you enter on this application is considered public information pursuant to the Information Practices Act (Civil Code section 1798 et seq.) and the Public Records Act (Government Code section 6250 et seq.) and will be placed on the Internet upon licensure. If you do not wish your residence address to be available to the public, you may provide a post office box number or a personal mailbox (PMB). However, if your address of record is not your residence address, you must also provide your residence address as an alternate address that will not be available to the public.

TO BE COMPLETED BY DEAN OF COLLEGE (If presently enrolled)

I, _____ (Name of Dean)	being Dean of _____ (Name of school or college)	
a school or college of pharmacy recognized by the California State Board of Pharmacy, do hereby certify that:		

(Name of Student)		
whose application for intern pharmacist registration is shown on this form, is:		
<input type="checkbox"/> registered as a student in this institution seeking a degree in pharmacy.		
<input type="checkbox"/> re-enrolled to satisfy the requirements of Business and Professions Code section 4200.1		
Emboss School Seal Here		
Year in school _____ Expected date of graduation _____		
_____	_____	_____
Signature	Title	Date

DO NOT WRITE BELOW THIS LINE

Livescan/FP Cards <input type="checkbox"/>	Registration no _____	App fee no. _____
FP Clear <input type="checkbox"/>	Date issued _____	Amount _____
Photo <input type="checkbox"/>	Date expires _____	Date cashiered _____
Rules <input type="checkbox"/>		
Enf <input type="checkbox"/>		

1. Are you a candidate for the licensure examination? Yes ☐ No ☐
2. Have you previously applied for registration as an intern pharmacist with the board? If "yes", please provide date and intern registration number _____ Yes ☐ No ☐
3. Have you ever taken the California pharmacist licensure exam? If "yes", please provide date of exam _____ Yes ☐ No ☐
4. Have you ever applied and not taken the exam? If "yes", please provide exam date _____ Yes ☐ No ☐
5. Have you ever been expelled from a pharmacist licensure exam administered in this state or any other state? If "yes", please provide the date and state _____ Yes ☐ No ☐
6. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety without exposing others to significant health and safety risks? If "yes", please attach a statement of explanation. If "no", proceed to #7. Yes ☐ No ☐

Are the limitations caused by your medical condition reduced or improved because you receive ongoing treatment or participate in a monitoring program? If "yes", please attach a statement of explanation. Yes ☐ No ☐

If you do receive ongoing treatment or participate in a monitoring program, the board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.
7. Do you currently engage or have you been engaged in the past two years, in the illegal use of controlled substances? Yes ☐ No ☐

If "yes", are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If "yes", please attach a statement of explanation.
8. Have you ever been convicted of or pled no contest to a violation of any law of the United States, a foreign country or any state laws or local ordinances? You must include all misdemeanor and felony convictions, regardless of the age of the conviction, including those which have been set aside under Penal Code section 1203.4 (Traffic violations of \$500 or less need not be reported). Yes ☐ No ☐

If "yes", please attach an explanation which must include the type of violation, the date, circumstances, location, and the complete penalty received.
9. Has disciplinary action ever been taken against your pharmacist or intern permit in this state or any other state? If "yes", please attach a statement of explanation. Yes ☐ No ☐
10. Have you ever had an application for a pharmacist license or an intern permit denied in this state or any other state? If "yes", please provide a statement of explanation. Yes ☐ No ☐
11. Have you had a pharmacy permit, or any professional or vocational license or registration denied, suspended, revoked, or placed on probation or other disciplinary action taken by this or any other governmental authority in this state or any other state? If "yes", please provide the name of company, type of permit, type of action, year of action and state. Yes ☐ No ☐
12. Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator or medical director on a permit to conduct a pharmacy, wholesaler, medical device retailer or any other entity licensed in this state or any other state? If "yes", please provide company name, type of permit, permit number and state. Yes ☐ No ☐

You must provide a written explanation for all affirmative answers to questions 9 through 15. Failure to do so will ultimately result in this application being deemed withdrawn as incomplete.

Please read carefully and sign below.

I understand that, as an intern pharmacist, I may not perform any duties required of a pharmacist except when I am working under the direct and personal supervision of a pharmacist. I also understand that should I perform any duties for which I am not licensed or should I take charge of and operate a pharmacy in the absence of a pharmacist, I am placing my ability to become a licensed pharmacist in jeopardy.

I further understand that I must submit a record of my intern pharmacist experience on a form furnished by the Board, certified by the pharmacist under whose immediate supervision such experience was attained in order to receive credit for such experience toward completion of my experience requirement.

Applicant understands that falsification of the information on this form, may constitute grounds for denial or revocation of the registration. I hereby certify under penalty of perjury under the laws of the State of California that all statements, answers and representations made in the foregoing application, including all supplementary statements are true and correct. I also certify that I personally completed this application. I understand that I must notify the board in writing of any change of address during my internship. I have also read and understand the instructions attached to this application.

Signature of applicant (in full, no initials)

Date Signed

All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information will be used to determine qualifications for registration under the California Pharmacy Law. The official responsible for information maintenance is the Executive Officer, telephone (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814-6237. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on them by our agency, unless the records are identified as confidential information and exempted by Section 1798.38 of the Civil Code.

**** Disclosure of your U.S. social security account number is mandatory. Section 30 of the Business and Professions Code, section 17520 of the Family Code, and Public Law 94-455 (42 USC § 405(c)(2)(C)) authorize collection of your social security account number. Your social security account number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for child or family support in accordance with section 17520 of the Family Law Code and section 11350 of the Welfare and Institution Code, or for verification of license or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security account number your application will not be processed and you may be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.**

MANDATORY REPORTING

Under California law each person licensed by the Board of Pharmacy is a "mandated reporter" for child abuse or neglect purposes. Prior to commencing his or her employment, and as a prerequisite to that employment, all mandated reporters must sign a statement on a form provided to him or her by his or her employer to the effect that he or she has knowledge of the provisions of Section 11166 and will comply with those provisions.

California Penal Code section 11166 requires that all mandated reporters make a report to an agency specified in Penal Code section 11165.9 [generally law enforcement agencies] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter must make a report to the agency immediately or as soon as is practicably possible by telephone, and the mandated reporter must prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of Section 11166 is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars (\$1,000), or by both that imprisonment and fine. For further details about these requirements, consult Penal Code sections 11164, and following.



RULES OF PROFESSIONAL CONDUCT

(Please Sign and Return to the Board)

1714 OPERATIONAL STANDARDS AND SECURITY

- (d) Each pharmacist while on duty shall be responsible for the security of the prescription department, including provisions for effective control against theft or diversion of dangerous drugs and devices, and records for such drugs and devices. Possession of a key to the pharmacy where dangerous drugs and controlled substances are stored shall be restricted to a pharmacist.

1715.6 REPORTING DRUG LOSS

The owner shall report to the Board within thirty (30) days of discovery of any loss of the controlled substances, including their amounts and strengths.

1717. PHARMACEUTICAL PRACTICE

- (a) No medication shall be dispensed on prescription except in a new container which conforms with standards established in the official compendia.
Notwithstanding the above, a pharmacist may dispense and refill a prescription for non-liquid oral products in a clean multiple-drug patient medication package (patient med pak), provided (1) a patient med pak is reused only for the same patient; (2) no more than a one-month supply is dispensed at one time; and (3) each patient med pak bears an auxiliary label which reads, "store in a cool, dry place."
- (b) In addition to the requirements of section 4040, Business and Professions Code, the following information shall be maintained for each prescription on file and shall be readily retrievable:
 - (1) The date dispensed, and the name or initials of the dispensing pharmacist. All prescriptions filled or refilled by an intern pharmacist must also be initialed by the preceptor before they are dispensed.
 - (2) The brand name of the drug or device; or if a generic drug is dispensed, the distributor's name which appears on the commercial package label; and
 - (3) If a prescription for a drug or device is refilled, a record of each refill, quantity dispensed, if different, and the initials or name of the dispensing pharmacist.
 - (4) A new prescription must be created if there is a change in the drug, strength, prescriber or directions for use, unless a complete record of all such changes is otherwise maintained.
- (c) Promptly upon receipt of an orally transmitted prescription, the pharmacist shall reduce it to writing, and initial it, and identify it as an orally transmitted prescription. If the prescription is then dispensed by another pharmacist, the dispensing pharmacist shall also initial the prescription to identify him or herself.
All orally transmitted prescriptions shall be received and transcribed by a pharmacist prior to compounding, filling, dispensing or furnishing.
Chart orders as defined in section 4019 of the Business and Professions Code are not subject to the provisions of the subsection.
- (d) A pharmacist may furnish a drug or device pursuant to a written or oral order from a prescriber licensed in the State other than California in accordance with Business and Professions Code section 4005.
- (e) No licensee shall participate in any arrangement or agreement, whereby prescriptions, or prescription medications, may be left at, picked up from, accepted by, or delivered to any place not licensed as a retail pharmacy.
However, a licensee may pick up prescriptions at the office or home of the prescriber or pick up or deliver prescriptions or prescription medications at the office of or a residence designated by a

patient or at the hospital, institution, medical office or clinic at which the patient is present. The Board may in its sole discretion waive this application of the regulation for good cause shown.

- (f) A pharmacist may transfer a prescription for Schedule III, IV, or V controlled substances to another pharmacy for refill purposes in accordance with Title 21, Code of Federal Regulations, Section 1306.26.

Prescriptions for other dangerous drugs which are not controlled substances may also be transferred by direct communication between pharmacists or by the receiving pharmacist's access to prescriptions or electronic files that have been created or verified by a pharmacist at the transferring pharmacy. The receiving pharmacist shall create a written prescription, identifying it as a transferred prescription; and record the date of transfer and the original prescription number. When a prescription transfer is accomplished via direct access by the receiving pharmacist, the receiving pharmacist shall notify the transferring pharmacy of the transfer. A pharmacist at the transferring pharmacy shall then assure that there is a record of the prescription as having been transferred, and the date of transfer. Each pharmacy shall maintain inventory accountability and pharmacist accountability and dispense in accordance with the provisions of Section 1716.

Information maintained by each pharmacy shall at least include:

- (1) Identification of pharmacist(s) transferring information;
 - (2) Name and identification code or address of the pharmacy from which the prescription was received or to which the prescription was transferred, as appropriate;
 - (3) Original date and last dispensing date;
 - (4) Number of refills and date originally authorized;
 - (5) Number of refills remaining but not dispensed;
 - (6) Number of refills transferred.
- (g) The pharmacy must have written procedures that identify each individual pharmacist responsible for the filling of a prescription and a corresponding entry of information into an automated data processing system, or a manual record system, and the pharmacist shall create in his/her handwriting or through hand-initialing a record of such filling, not later than the beginning of the pharmacy's next operating day. Such record shall be maintained for at least three years.

1761. ERRONEOUS OR UNCERTAIN PRESCRIPTIONS

- (a) No pharmacist shall compound or dispense any prescription which contains any significant error, omission, irregularity, uncertainty, ambiguity, or alteration. Upon receipt of any such prescription, the pharmacist shall contact the prescriber to obtain the information needed to validate the prescription.
- (b) Even after conferring with the prescriber, a pharmacist shall not compound or dispense a controlled substance prescription where the pharmacist knows or has objective reason to know that said prescription was not issued for a legitimate medical purpose.

1764. UNAUTHORIZED DISCLOSURE OF PRESCRIPTIONS

No pharmacist shall exhibit, discuss, or reveal the contents of any prescription, therapeutic effect thereof, the nature, extent, or degree of illness suffered by any patient or medical information furnished by the prescriber with any person other than the patient or his or her authorized representative, the prescriber or other licensed practitioner then caring for the patient, another licensed pharmacist serving the patient, or a person duly authorized by law to receive such information.

1765. COMMISSIONS, GRATUITIES, REBATES

An unlawful commission, gratuity or rebate prescribed by this article and Business and Professions Code Section 650 includes the rendering by a pharmacist or pharmacy of consultant pharmaceutical services such as those required pursuant to Title 22, Division 5, Chapters 3 and 4 (skilled nursing facilities and intermediate care facilities) to a licensed health care facility for no cost, nominal cost, or below reasonable cost, if that pharmacist or pharmacy obtains patients, clients or customers and/or their prescription order from that licensed facility or entity.

The determination of the value of consultant pharmaceutical services rendered shall include, but not be limited to, the value of all goods and services furnished by the pharmacist or pharmacy to a licensed health care facility.

1793.1 DUTIES OF A REGISTERED PHARMACIST

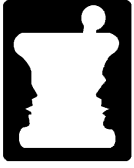
Only a registered pharmacist, or an intern pharmacist acting under the supervision of a registered pharmacist, may:

- (a) Receive a new prescription order orally from a prescriber or other person authorized by law.
- (b) Consult with a patient or his or her agent regarding a prescription, either prior to or after dispensing, or regarding any medical information contained in a patient medication record system or patient chart.
- (c) Identify, evaluate and interpret a prescription.
- (d) Interpret the clinical data in a patient medication record system or patient chart.
- (e) Consult with any prescriber, nurse or other health care professional or authorized agent thereof.
- (f) Supervise the packaging of drugs and check the packaging procedure and product upon completion.
- (g) Be responsible for all activities of pharmacy technicians to ensure that all such activities are performed completely, safely and without risk of harm to patients.
- (h) Perform any other duty which federal or state law or regulation authorizes only a registered pharmacist to perform.
- (i) Perform all functions which require professional judgement.

I hereby agree to abide by the Rules of Professional Conduct as they may, from time to time, be revised by the California State Board of Pharmacy.

Print Name of Applicant_____

Signature of Applicant_____ **Date** _____



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PHARMACY MANAGEMENT OBJECTIVE

(OPTIONAL)

The Board of Pharmacy, realizing the needs for a improved knowledge of pharmacy management, would encourage interns to achieve the following objectives to develop fundamental skills in economics, security, personnel development and patient relations.

1. The Intern shall be able to discuss the underlying principles of preparation of a budget, daily transactions and fiscal constraints necessary in the management of the pharmacy.
2. The Intern shall be able to accurately price a prescription, OTC medication and other health related items and have an understanding of pricing policies.
3. The Intern shall be able to efficiently order drug supplies both direct and wholesale courses.
4. The Intern shall be able to discuss and demonstrate methods of inventory control and its relationship to good purchasing procedure.
5. The Intern shall be able to discuss the various prepaid or third party plans and their procedures and able to accurately complete and submit the appropriate forms for reimbursement.
6. The Intern shall be able to discuss the effective and appropriate utilization and supervision of ancillary personnel.
7. The Intern shall be capable of performing security procedures within the pharmacy.

1719. Requirements For Admission to Examination.

- (a) Applicants for the pharmacist licensure examination shall have completed all requirements to graduation from a school of pharmacy accredited by the American Council on Pharmaceutical Education or recognized by the Board.
- (b) As of July 1, 1986 all candidates for the pharmacist licensure examination shall have completed a minimum of 1,000 hours of experience prior to applying for the examination.

1728. Intern Experience - Requirements for Licensure

- (a) Minimum Hours: All intern pharmacists must complete 1,500 hours of experience as a prerequisite to licensure.
 - (1) First Year Maximum: A maximum of 250 of the recognized 1,500 hours may be obtained during the first year of pharmacy education in a program sponsored by a school of pharmacy recognized by the Board.
 - (2) Preceptor Supervision: A minimum of 900 of the required 1,500 hours must be obtained in a pharmacy under the supervision of a preceptor.
 - (3) Board approved Experience: A maximum of 600 of the required 1,500 hours may be granted at the discretion of the Board for other experience which substantially relates to the practice of pharmacy.
- (b) Required Area of Experience: Effective January 1, 1986 all applicants for licensure must complete experience in both community pharmacy and institutional pharmacy practice setting in the following areas.
 - (1) Receiving and interpreting the prescription;
 - (2) Patient medication profiles;
 - (3) Prescription preparation;
 - (4) Consultation;
 - (5) Record keeping;
 - (6) Over the counter products;
 - (7) Drug Information
- (c) Proof of Experience: All intern Pharmacists are required to submit proof of experience on Board approved affidavits which shall be certified by the preceptor under whose immediate supervision such experience was obtained.
- (d) Out-of-State Exemption: One who is licensed as a pharmacist in any state and who has practiced as a pharmacist in the state for at least one year, as certified by the Board of Pharmacy of that state, shall be exempt from pharmaceutical requirements of this section.

Effective August 14, 1985.

**INSTRUCTIONS FOR COMPLETING A
"REQUEST FOR LIVE SCAN SERVICE" FORM
(California Residents)**

The following instructions are provided to assist you in completing this form accurately. Please follow all instructions carefully and print clearly; failure to do so may result in processing delays of your application.

1. **Job Title or Type of License, Certification, or Permit:** Enter the type of license, certification or permit for which you are applying. Appropriate license types include pharmacist, pharmacy technician, intern pharmacist, exemptee, or if an owner or officer of a pharmacy, hospital, clinic, wholesaler or hypodermic permit enter appropriate title of the facility.
2. **Name of Applicant:** Enter your last name, first name and middle name. Do not use initials or name abbreviations.
3. **AKA:** Enter all other names you have used, including your maiden name.
4. **CDL No:** Your California Driver's License Number.
5. **DOB:** Your date of birth (month/day/year).
6. **SEX:** Your gender (male or female).
7. **HT:** Your height in feet and inches.
8. **WT:** Your weight in pounds.
9. **Misc. No.:** Enter other identifying numbers. (e.g., Other State Driver's License Number)
10. **EYE Color:** Color of your eyes
11. **HAIR Color:** Color of your hair
12. **Home Address:** Your residence address
13. **POB:** Enter your place of birth.
14. **SOC:** Enter your Social Security Number

Take the completed form to your nearest Live Scan site for fingerprint scanning. There are more than 130 Live Scan sites throughout the state. An up-to-date Live Scan site list is on the Department of Justice's (DOJ) Internet web page at <http://caag.state.ca.us/app/contact.pdf> or call your local police or sheriff's department.

Contact the live scan service for hours of operation, an appointment (if necessary), acceptable forms of payment and identification requirements. Be prepared to pay **ALL applicable fees** (the DOJ processing fee of \$32 and fingerprint scanning service fee) at the time your prints are taken. The live scan fingerprinting service fee varies from about \$5 to \$20. The cost to electronically submit your fingerprints is determined by the local Live Scan agency and the agency can charge a fee sufficient to recover its costs.

The lower portion of the Request for Live Scan Service form must be completed by the live scan operator. The original of the form is retained by the scanning service; the second copy is to be attached to your application and submitted to the board; and the third copy is for your records.

FINGERPRINTING AUTHORITY

Section 144(b) of the Business and Professions Code authorizes the Board of Pharmacy to require an applicant for licensure to furnish a full set of fingerprints for purposes of conducting criminal history record checks. Fingerprints are required in order for the DOJ to conduct background checks for criminal convictions.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: _____ Type of Application: (check one) ☐ Employment ☐ License, Certification, Permit ☐ Volunteer
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: _____

Agency Address Set Contributing Agency:

_____		_____
Agency authorized to receive criminal history information		Mail Code (five-digit code assigned by DOJ)
_____		_____
Street No.	Street or PO Box	Contact Name (Mandatory for all school submissions)
_____		()
City	State	Zip Code
		Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____ CDL No. _____
Last First

DOB: _____ SEX: ☐ Male ☐ Female Misc. No. **BIL** - _____
Agency Billing Number (if applicable)

HT: _____ WT: _____ Misc. No. _____

EYE Color: _____ HAIR Color: _____ Home Address: _____

POB: _____ Street or PO Box _____

SOC: _____ City, State and Zip Code _____

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service DOJ ☐ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

Employer Name

Street No. Street or PO Box Mail Code (five digit code assigned by DOJ)

()

City State Zip Code Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: _____ Type of Application: (check one) ☐ Employment ☐ License, Certification, Permit ☐ Volunteer
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: _____

Agency Address Set Contributing Agency:

_____		_____
Agency authorized to receive criminal history information		Mail Code (five-digit code assigned by DOJ)
_____	_____	_____
Street No.	Street or PO Box	Contact Name (Mandatory for all school submissions)
_____		()
_____	_____	_____
City	State	Zip Code
_____		Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____ CDL No. _____
Last First

DOB: _____ SEX: ☐ Male ☐ Female Misc. No. **BIL** - _____
Agency Billing Number (if applicable)

HT: _____ WT: _____ Misc. No. _____

EYE Color: _____ HAIR Color: _____ Home Address: _____

POB: _____ Street or PO Box _____

SOC: _____ City, State and Zip Code _____

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service DOJ ☐ FBI ☐

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

Employer Name

Street No. Street or PO Box Mail Code (five digit code assigned by DOJ)

()

City State Zip Code Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: _____ Type of Application: (check one) ☐ Employment ☐ License, Certification, Permit ☐ Volunteer
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: _____

Agency Address Set Contributing Agency:

_____		_____
Agency authorized to receive criminal history information		Mail Code (five-digit code assigned by DOJ)
_____		_____
Street No.	Street or PO Box	Contact Name (Mandatory for all school submissions)
_____		()
City	State	Zip Code
		Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____ CDL No. _____
Last First

DOB: _____ SEX: ☐ Male ☐ Female Misc. No. **BIL** - _____
Agency Billing Number (if applicable)

HT: _____ WT: _____ Misc. No. _____

EYE Color: _____ HAIR Color: _____ Home Address: _____

POB: _____ Street or PO Box _____

SOC: _____ City, State and Zip Code _____

Your Number: _____
OCA No. (Agency Identifying No.)

If resubmission, list Original ATI No. _____

Level of Service DOJ ☐ FBI ☐

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

Employer Name

Street No. Street or PO Box Mail Code (five digit code assigned by DOJ)

()

City State Zip Code Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed